



COMMONWEALTH OF VIRGINIA
Department of Health Professions
Board of Counseling

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VERIFICATION OF EXPERIENCE WHILE UNDER SUPERVISION FOR CSAC-A

GENERAL INFORMATION		PLEASE TYPE OR PRINT CLEARLY	
Name of Applicant (Last, First, Middle)		Applicants Email Address	
SUPERVISOR'S EVALUATION:			
Supervisor's Name (Last, First)		Supervisor's License or Certification Number	Supervisor's Telephone Number
Worksite Name and Address where substance abuse tasks were performed:			
Dates of supervision: From: _____ to _____			
Did the applicant complete a minimum of 180 hours of experience performing the following tasks with substance abuse clients with <u>at least eight hours</u> for each task?		(Circle Yes or No)	
a. Screening clients and gathering information used in making the determination for the need for additional professional assistance;		Yes	No
b. Intake of clients by performing the administrative and initial assessment tasks necessary for admission to a program;		Yes	No
c. Orientation of new clients to program's rules, goals, procedures, services, costs and the rights of the client;		Yes	No
d. Assisting the client in identifying and ranking problems to be addressed, establish goals, and agree on treatment processes;		Yes	No
e. Implementation of substance abuse treatment plan as directed by the supervisor;		Yes	No
f. Implementation of case management activities that bring services, agencies, people and resources together in a planned framework of action to achieve established goals;		Yes	No
g. Assistance in identifying appropriate crisis intervention responses to clients; needs during acute mental, emotional or physical distress;		Yes	No
h. Education of clients by providing information about drug abuse and available services and resources;		Yes	No
i. Facilitating the client's utilization of available support systems and community resources to meet needs identified in clinical valuation or treatment planning;		Yes	No
j. Reporting and charting information about client's treatment, progress, and other client-related data; and		Yes	No
k. Consultation with other professionals to assure comprehensive quality care for the client		Yes	No
In your opinion has the applicant demonstrated competency sufficient for certification of substance abuse counseling?		Yes	No
I declare that, to the best of my knowledge, the foregoing is true and correct.			
_____ Supervisor's Signature		_____ Date	